

Heavy Menstrual Bleeding

Clinical Care Standard

The *Heavy Menstrual Bleeding Clinical Care Standard* aims to ensure that women with heavy menstrual bleeding are offered the least invasive and most effective treatment appropriate to their clinical needs and preferences and are able to make an informed choice from the range of treatments suitable to their individual situation.

1 Assessment and diagnosis

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

When assessing a patient with heavy menstrual bleeding, consider the diverse possible causes as per the PALM-COIEN classification system (refer to [Table 1](#)), and other possible diagnoses such as endometriosis or miscarriage.

Take a detailed history that includes:

- The nature of bleeding, including duration, frequency, heaviness and pattern (regular or irregular) (Note: post-coital, intermenstrual and postmenopausal bleeding require specific investigation.)
- The impact on quality of life, including impact on mental health and limitations on work, exercise and social functioning
- Related symptoms such as pelvic pain or pressure
- Symptoms suggestive of iron deficiency, with or without anaemia
- Sexual and reproductive health, including parity, desire for future fertility, contraception use, likelihood of pregnancy or miscarriage, risk of sexually transmitted infection and cervical screening status

- History or symptoms suggestive of systemic causes of bleeding, such as a bleeding disorder, polycystic ovary syndrome (PCOS) or thyroid disease
- Relevant family history, such as history of bleeding disorders, endometriosis or endometrial or colorectal cancer
- Current medications and use of over-the-counter supplements that may be associated with ovulation or bleeding
- Other factors that may affect treatment options, such as comorbidities or previous treatments for heavy menstrual bleeding.

Conduct a physical examination if appropriate and with consent. This will usually include a speculum examination, and a bimanual pelvic examination to identify any palpable mass or abnormal uterine size. Situations in which pelvic examination may be inappropriate include for women and adolescents who are not sexually active, women who have been sexually assaulted in the past, women who have experienced birth trauma, or women who decline for cultural reasons.

Exclude pregnancy with a urinary beta HCG if indicated. Routinely evaluate iron deficiency and anaemia with serum ferritin and a full blood count.

Arrange other investigations based on a careful history and presentation. These might include testing for bleeding disorders or thyroid dysfunction, a cervical screening test (if clinically indicated), genital swab tests (if clinically indicated) or ultrasound for assessment of uterine abnormalities. Refer to current guidelines such as Therapeutic Guidelines.

Consider using a validated health-related quality-of-life questionnaire to help inform clinical decision-making and monitor treatment effectiveness, and to inform quality improvement.

Discuss and arrange referral for any other support the patient may require, such as counselling, acknowledging the effect that heavy menstrual bleeding can have on emotional wellbeing and mental health.



Cultural safety and equity

- Recognise the social and cultural factors influencing a woman’s access to, and experience of, health care related to their heavy menstrual bleeding. These can include attitudes and norms that prevent the open discussion of menstruation, generate feelings of shame and embarrassment, and limit access to health information about menstruation.
- Be aware of Women’s Business and the wishes of many Aboriginal women to keep women’s health issues private and separate from other health issues.

- If appropriate, offer Aboriginal and Torres Strait Islander women access to culturally safe models of care, such as those offered through, or in partnership with, Aboriginal Community Controlled Health Organisations or Aboriginal and Torres Strait Islander health and medical services.
- Recognise that a history of trauma may affect a person’s experience of care.
- Consider the needs of trans and non-binary people who menstruate, who may find it difficult discussing menstrual issues or undergoing clinical examination.
- Recognise the diverse needs of women with disabilities and ensure they are assessed similarly to women without disability, including a comprehensive history, and appropriate examinations and investigations. Where required, make reasonable adjustments to support women with disabilities to access appropriate care.

Table 1: International Federation of Gynecology and Obstetrics (FIGO) classification system for causes of abnormal uterine bleeding* (PALM-COEIN)¹

Structural causes (PALM)		Non-structural causes (COEIN)	
P	Polyps	C	Coagulopathy
A	Adenomyosis	O	Ovulatory dysfunction
L	Leiomyoma (fibroids)	E	Endometrial
M	Malignancy or hyperplasia	I	Iatrogenic
		N	Not otherwise classified

* Heavy menstrual bleeding is the most common type of abnormal uterine bleeding. Other types include intermenstrual bleeding and post-coital bleeding.

2 Informed choice and shared decision making

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.

Shared decision making enables individuals' preferences and priorities to be considered alongside the best available evidence. It can lead to improved satisfaction and better-quality decisions. To support informed choice and shared decision making:

- Discuss the patient's condition, their treatment options and the benefits, risks and probable outcomes of possible treatments, including side effects and complications, and the possibility of treatment failure
- Discuss the patient's treatment goals and their preferences and priorities, including desire for pregnancy and/or future fertility
- Provide high-quality patient information in the most appropriate format based on their needs and preferences, for example, a fact sheet or link to a website
- Consider the use of decision aids to systematically address options and support informed choice
- Accept and acknowledge that the patient's informed view on the balance of benefits, risks and probable outcomes of treatments may differ from yours as a healthcare professional.



Cultural safety and equity

- Recognise the woman's personal and cultural beliefs which may influence decisions about investigations and treatments for heavy menstrual bleeding.
- Ensure that the information and education you provide is culturally appropriate and culturally safe.
- Use an interpreter if needed and provide written information in the patient's preferred language. Consider whether any aids are needed (for example, visual resources such as videos or flip charts).
- Offer women access to culturally appropriate services such as those offered through, or in partnership with, Aboriginal Community Controlled Health Organisations or Aboriginal and Torres Strait Islander health and medical services.

- Attend cultural safety training provided by your healthcare service or professional organisation.
- Recognise that women with disability have the same health care rights as women without disability, including the right to be offered the same options and to be involved in decisions about their care. As for any patient, consider any specific communication needs, and their decision-making capability. If needed, make reasonable adjustments to support their understanding and facilitate their involvement in decision-making, even for women with a nominated substitute decision-maker. Assess whether a multidisciplinary approach is required.

3 Initiating medical management

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.

Consider medical management of heavy menstrual bleeding before more invasive treatment options. In the absence of significant pathology, many patients with heavy menstrual bleeding may be effectively managed with medical therapy alone.

Discuss the medical options available, including hormonal and non-hormonal therapy and explain what to expect from each, including benefits, risks and probable outcomes. The choice of therapy will be influenced by the woman's preferences and priorities, including her need for contraception, the cause(s) of bleeding, coexisting conditions, and associated symptoms requiring further investigation, including pressure and pain. Medical options include:

- Non-hormonal options, including tranexamic acid (an *antifibrinolytic*) and non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, mefenamic acid or naproxen, which reduce blood flow and/or provide analgesia during menstruation
- Hormonal options, including combined oral contraceptives, oral progestogens or depot medroxyprogesterone; oral hormones may be taken intermittently (during a menstrual cycle) or continuously after discussion of issues, implications for contraception and side effects

- A 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD), which is currently the most effective medical therapy for heavy menstrual bleeding in women without significant pathology, in addition to its contraceptive action (see Quality statement 5 – [Intrauterine hormonal devices](#)).

When clinically appropriate, offer initial oral treatment such as tranexamic acid and/or NSAIDs at first presentation to relieve symptoms and limit complications (for example, from iron deficiency) if the patient's preferred treatment option is not immediately apparent or available, when further investigations are recommended, or the patient needs to wait for further appointments (for example, for insertion of the LNG-IUD).

Support patients to participate in shared decision making about their treatment options.

Advise patients they should return for review if their initial chosen treatment option is unsatisfactory.

Refer to Therapeutic Guidelines, the *Australian Medicines Handbook* or clinical guidelines for information regarding efficacy, contraindications, adverse effects and treatment regimens.

4 Quality ultrasound

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.

Based on the initial assessment, an ultrasound may be required to investigate structural causes of heavy menstrual bleeding, such as in patients:

- With an increased risk of malignancy based on history (for example, risk factors such as older age, personal or family history of endometrial or colorectal cancer, use of unopposed oestrogen or tamoxifen, obesity, young age at menarche or older age at menopause, nulliparity, diabetes or endometrial hyperplasia)
- With features suggestive of pathology on examination (for example, an enlarged or irregular uterus, suggesting fibroids)
- With symptoms such as deep dyspareunia, severe dysmenorrhoea or secondary heavy menstrual bleeding
- Who have not responded to a reasonable duration of medical management.

Whether ultrasound is required prior to insertion of the LNG-IUD depends on the patient's age and likelihood of pathology or of structural abnormalities which could influence appropriate positioning of the device.

When ultrasound is indicated, offer transvaginal ultrasound as first-line imaging to allow a more detailed assessment of the pelvic structures, including the uterus and endometrium. Transvaginal ultrasound is usually performed in conjunction with a transabdominal ultrasound.

Before a transvaginal ultrasound is conducted or requested, the patient should be advised about how it will be performed so they have the opportunity to decline. If transvaginal ultrasound is inappropriate, or the woman chooses not to have it, then offer transabdominal ultrasound alone; referring clinicians should note this on the request form. Transvaginal ultrasound may be inappropriate, for example, for non-sexually active adolescents and women, women with a history of sexual assault, women with an experience of birth trauma, or women who decline for cultural reasons.

Sonographers and sonologists should ensure that patients provide informed consent in relation to ultrasound.

When referring for ultrasound, request that it be performed on days 5–10 of the menstrual cycle. This allows the most accurate measurement of endometrial thickness which is used in risk assessment for endometrial hyperplasia and malignancy and improves detection of polyps. Bear in mind that it may be difficult for some women to arrange an ultrasound at this time (for example, those with unpredictable or irregular cycles and those in areas with limited access to imaging services). When referring, communicate requirements to support appropriate access. Offer initial oral treatment where clinically appropriate to relieve symptoms and limit complications while the woman is waiting for an appointment.

5 Intrauterine hormonal devices

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.

When considering medical management:

- Offer a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD) to the patient whenever it is clinically suitable – evidence supports the use of the LNG-IUD to treat heavy menstrual bleeding in patients without malignancy or other significant pathology because it is more effective and provides greater improvements in quality of life compared with other medical treatments
- Discuss the benefits and risks of the LNG-IUD and explain what to expect, including that it may take three to six months or more to experience the full benefit of the treatment (see *Therapeutic Guidelines* or *Australian Medicines Handbook* for more information)
- If necessary, refer the patient to a trained practitioner for insertion of the LNG-IUD.

Consider whether pelvic ultrasound is indicated before or at the same time as inserting the LNG-IUD, such as when other treatments have not been effective or if the patient has risk factors for gynaecological disease, including age or findings on examination or history.

If the patient requires an ultrasound and/or further assessment before the LNG-IUD is inserted, offer initial oral treatment where clinically appropriate to relieve symptoms and limit complications (such as iron deficiency) while they wait. (See Quality statement 3 – [Initiating medical management.](#))

6 Specialist referral

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.

From primary care, offer early referral to appropriate specialist care for patients with:

- Suspicious clinical findings on assessment or ultrasound. Consider risk factors for endometrial cancer such as
 - age, with increased suspicion warranted in a woman aged over 45
 - personal or family history of endometrial cancer or colorectal cancer
 - use of unopposed oestrogen or tamoxifen
 - obesity
 - young age at menarche or older age at menopause
 - nulliparity
 - diabetes
 - endometrial hyperplasia
- Significant pelvic pathology on ultrasound such as large fibroids or endometrial polyps
- Severe symptoms at initial presentation.

Early referral is also warranted if medical management is unsuitable, or if a patient requests procedural treatment options.

For patients who have not responded to medical management, offer referral for further investigation and treatment.

When referring to specialist care, arrange for appropriate investigations, including cervical screening and ultrasound, to be completed.

7 Uterine-preserving alternatives to hysterectomy

A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.

When non-medical management options are being considered, discuss uterine-preserving procedures that may be suitable for the patient's clinical situation. These may include:

- **Endometrial ablation** – a minimally invasive surgical procedure for women without substantive structural uterine pathology and who have no desire for future pregnancy. It involves the removal or destruction of the endometrium including the basal layer using one of a variety of techniques including resection and/or ablation, laser, bipolar radiofrequency or thermal balloon ablation. Women must be informed about the need for contraception following endometrial ablation.
- **Uterine artery embolisation (UAE)** – a minimally invasive treatment option for women with fibroids. The procedure is done by an interventional radiologist. It involves a small incision in the groin or wrist through which a catheter is taken to the uterine arteries. Embolisation is performed by injecting particles to the arteries supplying the fibroids. Successful pregnancy may be possible after UAE. However, myomectomy is preferred, if clinically appropriate, for women who desire future pregnancy. Women considering UAE and desiring fertility should be counselled based on current available evidence regarding future pregnancy and potential risks.

- **Myomectomy** – the surgical removal of uterine fibroids. Myomectomy preserves the uterus and is an option for women who wish to retain their fertility. Myomectomy can be conducted using laparotomy, laparoscopy, or hysteroscopy.
- **Hysteroscopic resection** of intracavitary pathology (such as polyps or myomas) where these are considered to be causing or contributing to heavy menstrual bleeding. In this procedure, a hysteroscope is passed into the uterine cavity through the vagina. Pathology can be removed using electrosurgical, mechanical, laser or thermal energy.

Consider appropriateness, contraindications and possible complications for each procedure in the context of the patient's specific uterine pathology and clinical presentation, and their preferences and priorities, including their desire for future fertility.

Discuss the relevant options fully with the patient. If they would prefer to consider a treatment choice that you are unable to provide, offer referral for assessment, and/or to discuss the procedure, with a suitably qualified specialist or service.



8 Hysterectomy

Hysterectomy to manage heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

When discussing the range of treatment options for heavy menstrual bleeding, support the patient to consider less invasive alternatives prior to considering hysterectomy, as appropriate to their clinical situation and personal circumstances.

Hysterectomy is generally considered when alternative medical and procedural options are unsuitable, have proven to be ineffective or intolerable, or when it is the patient's preference.

When the patient is considering hysterectomy, ensure that they understand the benefits, risks and probable outcomes of the surgery. Discuss minimally invasive approaches to hysterectomy (vaginal or laparoscopic) where clinically appropriate.

When the patient is making their decision, allow them the time and opportunity to consider this information.

The discussion should cover the irreversible nature of the surgery, consequences for childbearing, risks including infection, organ damage and blood loss, the time in hospital and the recovery period. Explain any particular risks associated with the type(s) of hysterectomy being considered.

Questions?



Find out more about the *Heavy Menstrual Bleeding Clinical Care Standard* and other resources. Scan the QR code or use the link safetyandquality.gov.au/hmb-ccs.

References

1. Munro MG, Critchley HOD, Fraser IS. The two FIGO systems for normal and abnormal uterine bleeding symptoms and classification of causes of abnormal uterine bleeding in the reproductive years: 2018 revisions. *Int J Gynaecol Obstet* 2018;143(3):393–408

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.